



NC DEPARTMENT OF  
HEALTH AND  
HUMAN SERVICES

*COVID-19: Best Practices in Congregate Care Settings*

Supplemental Guidance to Trainings Conducted on April 9, 2020

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## Introduction

The COVID-19 pandemic poses an unprecedented challenge for supporting people in congregate living settings. On April 7, in collaboration with its partners, the NC Department of Health and Human Services (NC DHHS) hosted a “refresher” training series, *COVID-19: Best Practices in Congregate Care*. Over 2,000 attendees joined these sessions, representing the full spectrum of congregate living providers. Recognizing the diversity among these settings and in consideration of person-centered practices, NC DHHS has developed this supplemental guidance, integrating questions raised during the training series.

This supplement was jointly developed by staff from the Division of Public Health, the North Carolina Statewide Program for Infection Control and Epidemiology (NC SPICE), the Division of Health Services Regulation, the Division of Mental Health Developmental Disabilities and Substance Abuse and the Division of Health Benefits. All guidance should be considered current as of the supplement’s posting date but is subject to revision. NC DHHS also appreciates the contributions of the NC Council on Developmental Disabilities, provider associations and community stakeholders who supported the webinar series and informed the content provided here. This supplement was developed under COVID-related time constraints in a rapidly evolving context. We have attempted to ensure that guidance provided is clear but recognize that readers may require additional clarification based on individual circumstance or evolving guidance. Please contact your local county health department if you have follow up questions about how this guidance applies to your specific circumstance. A link to all county health departments is provided [here](#).

NC DHHS recognizes the extraordinary and very setting-specific challenges COVID-19 poses to all residents, families and providers. NC DHHS appreciates feedback on how it can provide content that is relevant to its stakeholders during this exceptional time.

## Access to Materials and Resources

Links to all *Best Practices in Congregate Settings* webinar materials are available under the [Long-term Care Facilities section of the Department’s COVID-19 Guidance webpage](#).

Throughout this document, text has been hyperlinked for quick access to relevant documents or guidance. Please click on the link provided or [embedded text that looks like this](#).

## Aligning with Licensure Requirements

**Note to all licensed providers and providers who are Medicare and/or Medicaid certified:**

Nothing in this supplement alters or modifies any state or federal laws, regulations or waiver requests related to your licensure or certification.

- For nursing homes, additional information about state licensure requirements and federal certification requirements may be found at: <https://info.ncdhhs.gov/dhsr/nhlcs/rules.html> .
- For Adult Care Homes, additional information about state licensure requirements may be found at: <https://info.ncdhhs.gov/dhsr/acls/rules.html>.
- For licensed providers of ICFs/IDD and MH/DD/SA group homes, additional information about state licensure requirements may be found at: <https://info.ncdhhs.gov/dhsr/mhlcs/rules.html>

### What is Meant By “Smaller Residential Settings”

Recognizing that much of the COVID-19 guidance developed for congregate care settings targets larger, long-term care facilities, this supplement attempts to clarify how the published public health standards are most appropriately applied in smaller residential settings. Due to the variety of arrangements in which people live, “smaller residential settings” is not tied to any specific arrangement or licensing designation. Guidance targeting “smaller residential settings” has been deemed appropriate for provider-managed households with 6 or fewer residents.

## COVID-19: General Information

### **What is the level of risk of an influx in congregate care VS normal population – assuming reasonable mitigation strategies are in place - Entry screening, social distancing, required facial coverings etc.?**

Nursing homes, assisted living facilities, and other long-term and residential facilities have vulnerable residents at high risk of COVID-19. The hospitalization rate for COVID-19 is highest in persons >65 years of age (13.8/100,000).

### **Who is at higher risk for severe illness?**

According to [CDC](#), those at highest risk for severe illness include:

- People 65 years and older
- People who live in a nursing home or long-term care facility
- People with underlying medical conditions

### **What is the guidance for people with asthma?**

Please see CDC- issued guidance, for people with [moderate to severe asthma](#).

## COVID-19: Symptom Identification

### **What are signs and symptoms of COVID-19?**

- A wide range of symptoms have been reported by individuals with COVID-19.
- The most common signs and symptoms for COVID-19 include
  - fever
  - cough
  - shortness of breath or difficulty breathing
- Other reported signs and symptoms include chills, muscle pain, headache, and sore throat.
- It typically takes between 2-14 days for symptoms to start after an individual is exposed.
- Please see [CDC guidance for additional information](#).

### **What is considered a “temperature?”**

- Residents should be asked to report if they feel feverish and residents should be actively monitor at time of admission and at least daily for fever ( $T \geq 100^{\circ}\text{F}$ ).
- Older adults with COVID-19 may not show typical symptoms of fever or respiratory distress. Atypical symptoms may include new or worsening malaise, new dizziness, or diarrhea.

## Applying COVID-19 Standards to Smaller Residential Settings

### Do all COVID-19 Preventive Measures and Interventions for Long-Term Care Facilities Apply to Smaller Residential Settings?

#### **Current Guidance:**

COVID guidance directed at long-term care settings provides an important “starting place” for all residential settings, regardless of size. However, specific preventive measures and interventions may not be viable or appropriate in smaller residential settings. Each circumstance should be considered individually, and efforts should strive to align the key themes of effective intervention and support outlined in this section under Additional Clarification.

The Department has published guidance for [long-term settings](#) and [group homes](#) which *all* providers of smaller residential settings should review for pre-published recommendations that may inform your specific scenario. Further, the Department’s guidance for [home and community-based care providers](#) may provide useful guidance for smaller residential settings. The CDC has also published a nursing facility guidance checklist that may help inform the preparation for all providers. All guidance can be found at [All Guidance for All Providers and Local Health Departments](#). Please note, due the rapid progression of the COVID pandemic, resources may be updated regularly. Please look for updates through your typical communication channels and through the NC DHHS website. Importantly, providers should know and align with licensing requirements related to infection prevention practices applicable to the particular setting.

Person-centered resources for older adults and people with disabilities are available through the [NC Council on Developmental Disabilities](#) (NCCDD) website. Disability-sensitive information has also been developed and curated by the [Administration on Community Living](#), [Substance Abuse Mental Health Services Administration \(SAMHSA\)](#), [National Council on Independent Living](#) and others.

#### **NEED GUIDANCE ON HOW TO SUPPORT RESIDENTS WHO MAY BE COVID+?**

##### **The County Local Health Department**

- Guidance on how public health guidance applies to your specific circumstance.
- To seek guidance on symptoms and testing.
- To report a positive case.
- Link to health department for each county is [here](#).

##### **The Resident’s Primary Care Provider**

- To seek guidance on symptoms and testing
- To seek guidance of symptom management and escalation.

##### **CCNC’s COVID-19 Triage Plus Information Line**

- Nurse care manager-staffed call line to assist individual Medicaid beneficiaries and other NC residents with COVID-19 needs.
- Link to more information is [here](#).

## **Additional Clarification: Foundational Strategies for All Settings**

COVID-19 prevention and management strategies used will vary by setting size and the circumstances of the residents. NC DHHS supports individual residential providers' use of judgment consistent with applicable licensure requirements and public health recommendations. The following prevention and mitigation strategies should be considered foundational and implemented, regardless of residential setting type or size.

### **PREVENT INFECTION BY:**

- ✓ LIMITING travel outside the residence.
- ✓ LIMITING visitors to the residence.
- ✓ PRACTICING effective hand hygiene (i.e. hand-washing) and respiratory hygiene (i.e. sneezing into one's elbow and away from others) of both residents and staff.
- ✓ FREQUENT disinfection of common spaces, using [EPA-grade](#) disinfectant where possible or required.
- ✓ SOCIAL DISTANCING wherever practicable.
- ✓ MONITORING residents and staff regularly for symptoms.
- ✓ STREAMLINE staff scheduling as much as practicable to reduce the risk.
- ✓ WEARING cloth face coverings. Please see additional guidance under [header here]

### **ADDRESS INFECTION BY:**

- ✓ KNOWING what symptoms to look for.
- ✓ REPORTING if a person develops symptoms.
- ✓ GETTING CLINICAL GUIDANCE in decision making
- ✓ DISTANCING (also known as "isolating") COVID+ Resident from others in the household.
- ✓ CLEARLY COMMUNICATING with families and others, as appropriate and authorized.
- ✓ USING PPE as available.
- ✓ HELPING a person understand what is happening.

### **How do you appropriately socially distance in a small group residence?**

Establishing appropriate preventive measures for people living in small group residences requires thoughtful analysis. Congregate settings, particularly those with shared living spaces, are at higher risk of a COVID outbreak. However, preventive measures that unreasonably restrict a household member's access to the full use of his home may not be appropriate. Providers are encouraged to consider their individual circumstance and examine how social distancing could be appropriately applied to the setting.

Some examples of social distancing in smaller group residences:

- Residents having meals in their rooms, the living room or on the porch/patio, sitting six feet apart.
- Implementing new household practices aiming at preventing spread, such as sanitizing communal items like appliances, faucets and door handles after each use.
- Rotation scheduling for using common space, sanitizing after each use.
- Creating additional outdoor space to better enable social distancing.
- Use of a cloth facemask by residents, when leaving their room.

**Importantly**, COVID-19 disproportionately impacts residents who are medically vulnerable and/or experience co-morbidities. Strategies used should specifically incorporate a more stringent standard if any resident potentially meets this criterion.

**What if a resident doesn't understand these interventions or precautions and can't "comply" with them?**

All interventions should consider the person's individual circumstance and communication needs. Where applicable, engage the person's natural supports (family, friends) and staff who know the person well in developing an appropriate strategy.

**Additional Resources:**

- *COVID-19 Information By and For People with Disabilities (Green Mountain Self-Advocates plain language document)*  
<https://selfadvocacyinfo.org/wp-content/uploads/2020/03/Plain-Language-Information-on-Coronavirus.pdf> and [Plain Language Information on COVID-19 \(in 11 languages\)](#)
- *Coronavirus (COVID-19) Social Distancing With Children*  
<https://kidshealth.org/en/parents/coronavirus-social-distancing.html>
- Resources available through the Eldercare Locator, a public service of the U.S. Administration on Aging connecting you to services for older adults and their families. You can also reach us at [1-800-677-1116](tel:1-800-677-1116).
- Self-Advocate Resources and Technical Assistance (SARTAC) a project of Self-Advocates Becoming Empowered (SABE) - VIDEO: *What is Social Distancing? Self-Care - How to Take Care of Yourself During COVID-19*: [Click here](#). The PowerPoint only: [click here](#).

- *COVID-19: Advice for Caring for People with Alzheimers Disease and Mild Cognitive Impairment*  
<https://newsnetwork.mayoclinic.org/discussion/covid-19-advice-for-caring-for-people-with-alzheimers-disease-mild-cognitive-impairment/>

### **What if family members want to visit their loved one who resides in a smaller residential setting?**

#### **Current Guidance:**

- Visitors to a residence of any size increases the risk of transmitting the infection. All residential settings are urged to work with families to adhere to the [CDC's limited visitation policy for long-term care facilities](#).
- As noted in other sections, how this guidance is applied will depend on the residence and the person's specific circumstance.
  - Please note, the CDC and CMS have established rigorous guidance for nursing facilities and other larger, long-term settings, limiting visitation to end-of-life circumstances.
  - Additionally, NC DHHS has directly advised comparable visitation limitations for nursing facilities, adult care homes, family care homes and intermediate care Facilities for individuals with intellectual disabilities. Click [here](#) to view this visitation guidance.

#### **Considerations for Smaller Residential Settings:**

- Engage in person-specific and residence-wide dialogue with families to communicate needs and to determine the most appropriate method for adhering to public health guidance in your particular circumstance.
- Support alternative methods for communicating with families including teleconference or video conferencing or visiting in outdoor places while taking additional precautions related to mask and glove use and/or social distancing.
- If family member must visit within the residence, consider the following:
  - Apply the same screening precautions as are applied to staff entering the residence.
  - Discourage use of shared spaces, such as the household's kitchen or bathroom.
  - Disinfect the area used after use.
- **Using Therapeutic Leave Days**
  - Please see the recently published Medicaid [BULLETIN COVID-19 #45: Increase in Therapeutic Leave Days for ICF/IDD Facilities Due to COVID-19](#) for rules and guidance around utilizing Therapeutic Leave. The Bulletin specifically notes that, "[P]roviders may request that beneficiaries who choose extended therapeutic leave remain with their family to reduce potential exposure and adhere to Governor's EOs around social distancing. Providers who choose to allow



beneficiaries to return to their facility prior to the end of this crisis may implement [screening procedures recommended by the CDC](#) to determine if the beneficiary may return to the facility.” **Note:** this Bulletin applies to specific settings and does not apply to all congregate settings. Please review the Bulletin for specific guidance.

- **Additional Flexibilities Available to Congregate Care Settings Serving Residents Under a 1915(c) Waiver.**
  - *SPECIAL BULLETIN COVID-19 #55: NC Medicaid Receives Approval for Expanded Flexibilities for Home and Community-Based Services*  
<https://medicaid.ncdhhs.gov/blog/2020/04/21/special-bulletin-covid-19-55-nc-medicaid-receives-approval-expanded-flexibilities>
  - *SPECIAL BULLETIN COVID-19 #23: NC Innovations and NC TBI Waivers Community-Based Services (HCBS) Flexibilities for Waiver Beneficiaries Enrolled in 1915(c) HCBS Waivers*  
<https://medicaid.ncdhhs.gov/blog/2020/03/27/special-bulletin-covid-19-23-nc-innovations-and-nc-tbi-waivers-community-based>
- For additional guidance on Medicaid flexibilities for congregate care settings, please email: [Medicaid.COVID19@dhhs.nc.gov](mailto:Medicaid.COVID19@dhhs.nc.gov)

## New Admissions

### **Can a long-term care facility or residential setting require a negative COVID 19 test before admitting a new resident?**

If there is no clinical suspicion for COVID-19, testing for COVID-19 is not required. CMS states testing can be considered if available. Testing could be considered in non-urgent scenarios and when test results can be obtained in 24-48 hours. Since the ability to detect transmission is limited during the incubation phase, a negative test does not rule out COVID-19 and patients should still be placed on 14-day [transmission precautions](#) when transferred to long-term care. Long-term care facilities should NOT require two tests – two tests are only indicated to document resolution of symptoms after known COVID-19 diagnosis.

### **Can facilities admit and discharge residents during the State of Emergency?**

- Admissions and discharge requirements remain established under applicable regulatory authority and generally may continue.
- Facilities and residential settings may admit all individuals who would normally be admitted to your facility, including individuals from hospitals where a case of COVID-19 is/was present.
- However, please see guidance provided under other questions in this section prior to accepting new residents.

## **Should New Admissions be under a 14-day Quarantine?**

### **Current Guidance:**

- Settings can admit all individuals it would normally admit, including individuals from hospitals where a case of COVID-19 is/was present.
- All incoming residents should be quarantined (regardless of admission from a hospital, other facility, or home, and even if negative test) for 14 days before they enter the facility's general population.
- These residents should be quarantined separately from other residents who are quarantined due to contact with a COVID-19 case.
- New **admissions or readmissions** should either be placed in a private room (with bathroom) or in a separate observation area so the resident can be monitored for evidence of COVID-19. **This includes residents who had a negative COVID-19 test prior to admission to the facility.**
- A resident can be transferred to their usual room within the facility if they remain afebrile and without symptoms for 14 days after their admission. Testing at the end of this period could be considered to increase the certainty that the resident is not infected.
- All recommended PPE (gown, gloves, facemask, and eye protection) should be worn during care of residents under observation.

### **Additional Clarification for Smaller Residential Settings:**

- Governor Cooper's [Executive Order 131](#) "strongly encouraged" all long-term care settings, including adult care homes, family care homes, mental health group homes, and intermediate care facilities for people with IDD to adopt the risk mitigation measures directed at nursing facilities. The Department interprets the Order to cover other congregate care settings not expressly identified in the Order to also be covered under the Order's intent. Therefore, it is strongly advised that all new residents be distanced to the extent practicable in their new congregate living setting for a period of 14 days. If the resident was discharged from an acute care setting, congregate living settings should adhere to the requirements established throughout this guidance.
- If a smaller residential setting cannot effectively quarantine newly admitted residents, the provider should consider whether the new admission is appropriate during the State of Emergency. Any new admissions where quarantine protocols cannot be effectively implemented should be considered on case by case basis and in consultation with the county local health department.

## **Should we use enhanced precautions/additional PPE with newly admitted residents during quarantine?**

### **General Guidance:**

- All [recommended PPE](#) should be worn during care of residents under observation; this includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. **Cloth face coverings are not considered PPE and should not be worn by staff when PPE is indicated.** Please note that N95 (or higher) respirators should only be worn by people who have been fit-tested and medically cleared. Additionally, the facility must have a respiratory protection program
- As most recently noted in [What to Expect: Response to New Covid-19 Cases in Long-term Care Settings](#), if newly admitted resident has undiagnosed respiratory infection or confirmed COVID-19 diagnosis:
  - Wear appropriate [PPE](#).
  - As required by North Carolina Executive Order 131, implement universal use of face masks for all staff while in the facility if supplies are available.
  - Consider routine use of gloves for all patient interactions.
  - Please also see guidance provided under PPE section of this supplement.

### **Additional Clarification for Smaller Residential Settings:**

- Precautions used for newly admitted residents should align with the resident's specific circumstance.
- As noted above, under Executive Order 131, smaller residential settings are "strongly encouraged" to adhere to the guidance provided above.

## **If a resident has multiple negative tests before the 14-day quarantine ends, may they be moved to the general population?**

Since the ability to detect transmission is limited during the incubation phase, a negative test does not rule out COVID-19 and patients should still be placed on 14-day transmission precautions when transferred to long-term care.

## **May we accept new resident who is COVID-19 positive?**

Yes, so long as appropriate preventive measures and safeguards are in place.

## Additional Resources:

- *Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED)*  
<https://www.cms.gov/files/document/gso-20-14-nh-revised.pdf>
- *When should a BHIDD group home accept a resident who was diagnosed with COVID-19 from a hospital?*  
Available In [Interim Coronavirus Disease 2019 \(COVID-19\) General Guidance for Behavioral Health and Intellectual and Developmental Disability \(BHIDD\) Group Homes](#)

## Hand Hygiene

### **What is the guidance on use of hand sanitizer?**

CDC recommends washing your hands often with soap and water for at least 20 seconds especially after you have been in a public place, or after blowing your nose, coughing, or sneezing.

If soap and water are not readily available, use a hand sanitizer that contains at least 60% alcohol. Cover all surfaces of your hands and rub them together until they feel dry

Healthcare facilities should ensure that hand hygiene supplies are readily available to all personnel in every care location.

CDC and CMS state that an alcohol-based hand sanitizer should be in every resident room (ideally both inside and outside of the room) and sinks are well -stocked with soap and paper towels for handwashing.

CMS is aware of that there is a scarcity of some supplies in certain areas of the country, however it is expected that facilities will take actions to mitigate any resource shortages and show they are taking all appropriate steps to obtain the necessary supplies as soon as possible. For example, if there is a shortage of ABHR (alcohol-based hand rub), the expectation is for staff to practice effective hand washing with soap and water

Facilities should consider the resident's safety when deciding the most appropriate location for ABHR sanitizers. CMS states that vulnerable populations should not have access to ABHRs. In facilities where placing dispensers inside the room may pose a threat to patient safety considerations should be made for staff to carry personal pocket size hand sanitizers

There are no recommendations to disinfect gloves in clinical care areas. Gloves should be removed and discarded when leaving the care area and hand hygiene immediately performed.

## **Additional Resources:**

- *Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings*  
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>
- *Preparing for COVID-19: Long-term Care Facilities, Nursing Homes*  
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>
- *Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED)*  
<https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf>

## Cohorting, Separating and “Isolating” Residents

### **If a resident test positive, how do you effectively isolate or “cohort” that resident?**

#### **Current Guidance:**

- The goal of separating a COVID+ resident is to minimize the chance for transmission to other staff and residents.
- The resources under [NC DHHS COVID-19 Guidance for Long-term Care Facilities](#) provide guidance for isolating or “cohorting” (e.g., grouping) residents who test COVID + or who are suspected to be COVID +. For endorsed strategies, please visit site [Cohorting Residents to Prevent the Spread of COVID-19](#).

#### **Additional Guidance for Smaller Residential Settings:**

If effective isolation/separation is not possible, please contact your local health department to consider appropriate alternatives based on your individual circumstances.

### **Once you have a positive resident, can you remove from isolation after 14 days if they remain fever free and are asymptomatic?**

When residents have been confirmed to have COVID-19 there are two strategies to choose from, when making the decision to discontinue transmission-based precautions. Facilities and residential settings should utilize one of the following strategies below, in coordination with the resident’s health care provider and the county health department.

- **Test-based strategy (preferred method for residents in long-term care facilities):**
  - Resolution of fever without the use of fever-reducing medications **and**
  - Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**

- Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive nasopharyngeal swab specimens collected  $\geq 24$  hours apart (total of two negative specimens)
- **Non-test-based strategy:**
  - At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**,
  - At least 7 days have passed *since symptoms first appeared*.

#### **Additional Resources:**

- *NC Department of Health and Human Services: What to Expect: Response to New COVID-19 Cases or Outbreaks in Long Term Care Settings*  
[https://files.nc.gov/ncdhhs/documents/files/covid-19/What\\_To\\_Expect\\_Response\\_to\\_COVID19\\_Cases\\_Long\\_Term\\_Care.pdf](https://files.nc.gov/ncdhhs/documents/files/covid-19/What_To_Expect_Response_to_COVID19_Cases_Long_Term_Care.pdf)
- *Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance)*  
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html>

## Screening, Monitoring & Testing

### **Screening and Monitoring**

#### **Should all employees at the facility be screened daily? Or just healthcare personnel?**

**ALL** employees should be screened at the beginning of their shift for fever and symptoms of COVID-19.

- Facilities should actively take temperatures of **staff** and document absence of shortness of breath, new or change in cough, sore throat, and muscle aches. Fever is either measured temperature  $\geq 100^{\circ}\text{F}$  or subjective fever. If they are ill, have them keep their facemask on and leave the workplace
- Facilities should identify staff that work at multiple facilities (e.g., agency staff, regional or corporate staff, etc.) and actively screen and restrict them appropriately to ensure they do not place individuals in the facility at risk for COVID-19.

**Regarding daily monitoring of all residents, should we include additional assessments beyond temperature, signs of shortness of breath, sore throat, or cough?**

**ALL** residents should be screened at time of admission **and at least daily for fever** and symptoms of COVID-19:

- Facilities should actively take temperatures of **residents** ( $T \geq 100^{\circ}\text{F}$ ) and document absence of shortness of breath, new or change in cough, sore throat, and muscle aches at time of admission and at least daily. Older adults with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, new dizziness, or new diarrhea.
- New **admissions or readmissions** should either be placed in a private room (with bathroom) or in a separate observation area, so the resident can be monitored for evidence of COVID-19. ***This includes residents who had a negative COVID-19 test prior to admission to the facility.***
- Residents can be transferred to the main area of the facility if they remain afebrile and without symptoms for 14 days after their admission. Testing at the end of this period could be considered to increase the certainty that the resident is not infected.
- All recommended PPE (gown, gloves, facemask, and eye protection) should be worn during care of residents under observation

**For residents that have to go out to an emergent appointment or emergency room, are they screened upon re-entry, wear a mask, and isolate for 14 days?**

**Current Guidance:**

- Medically compromised residents who must regularly leave the facility for medically necessary purpose (e.g., residents leaving for hemodialysis) should wear a facemask, mask and gloves.
- All residents who leave the facility or setting should be screened and monitored as described in this section.
- If a resident must visit the emergency room or other high-risk setting, the resident should be screened and monitored. The provider may also consider quarantining (isolating) as a precaution.
- If resident is admitted or re-admitted to the facility after a hospitalization, the facility or residence should follow protocols referenced in the New Admissions section of this supplement.

**Additional Clarification for Smaller Residential Settings.**

- These safeguards listed under Current Guidance also apply.

**Additional Resources:**

- *Preparing for COVID-19: Long-term Care Facilities, Nursing Homes*  
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>

- *Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED)*  
<https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf>

## **Testing**

### **Given the apparent rate of spread in congregate care settings, can we expect to test all of residents & staff for the virus?**

#### **Current Guidance:**

- Please see NC's current guidance on testing, [here](#).
- Testing is available through a variety of commercial laboratories, health system laboratories, and the North Carolina State Laboratory of Public Health. Persons who live or work in a long-term care setting are considered a priority group for testing. People who live in or have frequent contact with these settings and have symptoms consistent with COVID-19 can be tested through the North Carolina State Laboratory of Public Health (NCSLPH). The LHD will assist to determine who should be tested and may recommend that all staff and residents be tested if feasible.

If it is not possible to test everyone, CDC has established a priority scale to help clinicians identify populations that are at greatest risk:

#### **Priority 1:**

- Hospitalized patient and symptomatic health care workers

#### **Priority 2:**

- Symptomatic residents in long-term care facilities, patients 65 years of age and older with symptoms, patients with underlying conditions with symptoms and first responders with symptoms

#### **Priority 3:**

- Critical infrastructure workers with symptoms, individuals who do not meet any of the above categories with symptoms, health care workers and first responders and individuals with mild symptoms in communities experiencing high COVID-19 hospitalizations

#### **Additional Resources:**

- *Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19)*  
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>



- NC Department of Health and Human Services: What to Expect: Response to New COVID-19 Cases or Outbreaks in Long Term Care Settings  
[https://files.nc.gov/ncdhhs/documents/files/covid-19/What\\_To\\_Expect\\_Response\\_to\\_COVID19\\_Cases\\_Long\\_Term\\_Care.pdf](https://files.nc.gov/ncdhhs/documents/files/covid-19/What_To_Expect_Response_to_COVID19_Cases_Long_Term_Care.pdf)

## **Return to Work**

### **How long should employees stay home before returning to work if they have symptoms?**

Employees who have symptoms of COVID-19 can return to work after meeting at least one of the following criteria:

- **Test-based strategy:**
  - Resolution of fever without the use of fever-reducing medications **and**
  - Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
  - Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive nasopharyngeal swab specimens collected  $\geq 24$  hours apart (total of two negative specimens)
- **Non-test-based strategy:**
  - At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**,
  - At least 7 days have passed *since symptoms first appeared*

Health care professionals with laboratory-confirmed COVID-19 who have not had any symptoms should be excluded from work until 10 days have passed since the date of their first positive COVID-19 diagnostic test assuming they have not subsequently developed symptoms since their positive test.

### **Additional Resources:**

- *Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19*  
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html>

## **Personal Protective Equipment (PPE): Use & Access**

### **What are PPE / masking recommendations for each type of facility/worker?**

- CMS has stated that “For the duration of the state of emergency in their State, all long-term care facility personnel should wear a facemask while they are in the facility.” This expectation is reinforced through [NC Executive Order 131](#). In addition, full PPE, including

gown, gloves and eye protection shall be worn for the care of any resident with known or suspected COVID-19.

- If COVID-19 transmission **occurs in the facility**, healthcare personnel should wear gown, gloves, facemask, and eye protection for the care of **all** residents irrespective of COVID-19 diagnosis or symptoms.
- N9 respirators or respirators that offer a higher level of protection should be used instead of a facemask when performing or present for an **aerosol generating procedure**.
- Cloth face coverings are not considered PPE because their capability to protect healthcare personnel (HCP) is unknown.
- Some healthcare personnel whose job duties do not require PPE (e.g., positions that would not normally have anticipated occupational exposure to blood, body fluids, secretions, excretions, i.e., clerical personnel) might continue to wear their cloth face covering for source control while in the healthcare facility.
- Secondary mask over or under your facemask should not be used as it can lead to contamination from additional handling and limit breathability through the mask.

#### **Additional Clarification for Smaller Residential Settings:**

- Consistent with Executive Order 131 staff in smaller residential settings should aspire to align with PPE requirements provided above and published by the Department.
- Recognizing the shortages of PPE, any staff supporting a resident or otherwise exposed to blood, body fluids, secretions or excretions (due to assistance with ADLs or other resident support) should wear a face **mask** in addition to other PPE already used (i.e. gloves) when engaged with that resident. Staff are otherwise advised to minimally wear a face **cover** (cloth mask) while in the setting and in public.
- Smaller residential setting staff should adhere to long-term facility standards when a resident is known or suspected to be COVID+

#### **Additional Resources:**

- *COVID-19 Long-Term Care Facility Guidance April 2, 2020*  
<https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf>
- *Interim Coronavirus Disease 2019 (COVID-19) Guidance on Personal Protective Equipment for NonMedical Setting, including In-Home Service and Non-Emergency Medical Transportation Providers*  
<https://files.nc.gov/ncdhhs/documents/files/covid-19/NC-Interim-Guidance-for-PPE-in-Non-Medical-Setting.pdf>

### **Provide care instructions for washing, storage etc. of reusable PPE**

The Occupational Health and Safety Administration (OSHA) defines *Personal Protective Equipment* (PPE) as specialized clothing or equipment worn by an employee for protection against a hazard. General work clothes (e.g., uniforms, pants, shirts or blouses) not intended to function as protection against a hazard are not considered to be personal protective equipment.

The employer shall clean, launder, and dispose of personal protective equipment required by this standard, at no cost to the employee.

PPE shortages are currently posing a tremendous challenge to the US healthcare system because of the COVID-19 pandemic. Care facilities are having difficulty accessing the needed PPE and are having to identify alternate ways to provide resident care.

In their guidance “Strategies for Optimizing PPE” CDC offers options for use when PPE supplies are stressed, running low or absent. Those strategies can be found at the link provided [here](#).

### **What is the guidance on use of masks by residents and staff?**

Use of a face covering, including surgical facemask and cloth mask applies regardless of whether residents/staff have been confirmed to have COVID-19 and regardless of facility size.

Please also see guidance provided under other questions within this section.

#### **Mask Use by Residents:**

Residents should wear a face covering, which can be a cloth mask, when leaving their room and/or when leaving the facility for medically necessary procedures.

#### **Mask Use by Staff:**

Staff responsible for direct resident care that would include anticipated occupational exposure to blood and/or body fluids should wear a surgical mask at all times when they are in the facility.

Staff that do not have anticipated occupational exposure to blood and/or body fluids should wear a mask (surgical mask as supplies allow; cloth mask/covering otherwise) at all times when they are in the setting.

### **Should uniforms be provided by employer to reduce bringing in or taking home possible germs? Should staff change their clothes before leaving?**

There is no recommendation for employers to furnish uniforms and/or staff change uniforms prior to leaving. PPE should be worn as appropriate.

## **PPE ACCESS**

As noted on the NC DHHS's website, personal protective equipment (PPE) has become one of the largest needs across our state during the COVID-19 pandemic. NCDHHS and the NC Department of Public Safety understand organizations across North Carolina are in need of PPE and state government is actively working to help get PPE to those who need it.

State leadership has put together a process for fulfillment of requests for PPE. In developing this process, the state is trying to make sure that those at highest risk of severe clinical disease and workers delivering emergent life-saving services are receiving the PPE they need. For additional information about requesting PPE in coordination with the Department, please visit: [NC DHHS' Requesting Personal Protective Equipment page.](#)

## **Other Questions**

### **Are there recommendations for introducing new staff/new hires into group homes during this time?**

There is no recommendation for or against hiring of new staff at this time. Facilities should adhere to all requirements for completion of new hire training and competency evaluations.

### **Are sitters, if utilized, considered essential workers?**

Information on essential businesses/workers are defined in [Executive Order NO. 121](#). It is the responsibility of the business/organizations to identify its mandatory/essential staff. Regardless of the setting's determination, sitters should be screened before entering the residential setting.